MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 12, 2001
10:27 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
AUTRY O.V. DeBUSK
GLENN M. HACKBARTH
FLOYD D. LOOP, M.D.
ALAN R. NELSON, M.D.
JANET G. NEWPORT
CAROL RAPHAEL
ROBERT D. REISCHAUER, Ph.D.
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA PAGE

MS. MUTTI: This presentation is on rural beneficiaries' access to care. The draft chapter is at your Tab G in your background materials. Before I start I want to offer a couple of caveats. One is that I have just recently taken responsibility for this chapter so some of the material is somewhat new to me. Fortunately, I have a few of my colleagues who have worked on certain parts of it here with me, so between us we should be able to answer your questions, and of course, if not, we'll get back to you.

Second of all, I'm sure you may have noticed as you were reading this chapter that there are certain holes in it, parts that we just didn't quite get a chance to fill out, collect all the information. We certainly intend in the next week or so to come back and address that. Particularly in the area of the providers that are located in rural areas, that's really short on material right now and really just placeholders there at the moment.

In this presentation I will summarize the chapter and ask for your feedback on one proposed recommendation

that was discussed at the last meeting, and then ask for your feedback also on overall content and tone. I think tone will be very important in this chapter.

The first part of the chapter assesses rural beneficiaries' access to care. It begins by a discussion on the challenges of measuring access to care and judging what is acceptable access to care. As we discussed at the lack meeting, there's a lack of a perfect benchmark or a definition of what is acceptable access to care. So we acknowledge that going in.

Also this chapter relies largely on MCBS data, and there are limitations to that data. While it provides a good overall national picture of access, it is not capable of reaching every pocket in the country, so we just need to bear that in mind as we consider the results.

As was discussed at the last meeting, rural beneficiaries are largely satisfied with the availability and the access to their care, both in absolute percentage and in comparison to their urban counterparts. For example, in terms of availability of medical care, 93 percent of

beneficiaries were satisfied across the board, both rural and urban. Satisfaction with specialist care was 95 percent, trouble getting care was just 3 to 4 percent. That was pretty consistent rural and urban.

The claims analysis supports these survey findings in terms of that both the urban and the rural beneficiaries showed up to be relatively similar, but there was certainly a difference. The claims analysis showed that fewer beneficiaries were getting their needed care.

There were two exceptions to these overall positive results, and that was remote rural beneficiaries did seem to show a little bit more concern for their access, and pretty much across the board the rural beneficiaries were more concerned about the high cost of care.

So we tried to come to some conclusions about this information, this analysis, and we start out by saying it's difficult to make a definitive conclusion about the effectiveness of Medicare's rural policies improving access. It's just there's not that link that will definitively show whether these programs have been successful, whether they

were improperly targeted and that we didn't reach some of our most remote beneficiaries, or that there was a lack of underlying need for them in the first place.

In addition, in this chapter we also note, as I said, that there's a lesser degree of satisfaction with access to care in remote rural areas, and we state that this warrants continued attention. But to balance out that, we should also note that the situation does not seem dire, especially taking into account some of the use data that you heard earlier this morning. We were unable to offer any systematic way of monitoring access in these real remote areas in the future, but we do acknowledge that it's important to keep an eye on it.

Then given concern that rural beneficiaries expressed about cost of care, MedPAC plans to study out-of-pocket cost and possible changes in cost sharing, such as coinsurance rates, that type of thing.

Our recommendation, we do have one recommendation in this chapter. This was discussed at the last meeting. It's that the Secretary should evaluate why rural

beneficiaries are not better represented in programs that cover Medicare cost sharing.

This recommendation reflects the fact that while rural beneficiaries are poorer than average than urban beneficiaries, they are not any more likely to be enrolled as a dual eligible to participate in the QMB program or the SLIMB program. That's qualified Medicare beneficiaries and specified low income Medicare beneficiary program. This might be particularly burdensome that they're not participating in these programs given that they pay a higher percentage out of pocket for Medicare-covered services and that some of their coinsurance may be going up, particularly OPD.

As you consider this recommendation this meeting, you might want to think if this reaches your threshold for something that you want to recommend the Secretary do a study on. Particularly, there has been other work in the past that has looked at the fact that there are relatively low participation rates in these programs across the board.

There are some suggested, sort of known

explanations for why some of these things occur. Certainly, some states, southern states with substantial Medicare rural populations may have very low poverty thresholds for even being eligible to be a dually eligible for both Medicaid and Medicare. Other barriers that have been identified by other studies are the fact that you have to have a face to face interview in order to be eligible for QMB or SLIMB. These are probably a likely barrier for why that would prevent rural beneficiaries from participating.

DR. WILENSKY: Anne, is there a reason that the focus is on evaluating on why something hasn't happened as opposed to directing the Secretary to find strategies that would increase enrollment in those programs that reduce cost sharing that are available?

MS. MUTTI: I don't think that there was a strong feeling going into it. I think that would be an acceptable way to reword this in a more positive way.

DR. WILENSKY: To the extent that we have programs like QMB and SLIMB and that enrollment is always an issue, directing more effort be made to increase the enrollment of

rural low income individuals in existing programs would be better than --

DR. NEWHOUSE: Why just rural?

DR. WILENSKY: Only to the extent that -- to increase in general, particularly in those areas where they're income adjusted differentially, poorly represented.

MS. MUTTI: Again, so just rewording, the Secretary should identify strategies to improve rural beneficiaries representation in these programs, something like that?

DR. WILENSKY: Right. I think in the text the point that Joe just raised, I think it's appropriate to attempt to increase enrollment for qualified individuals in QMB and SLIMB in all areas. But this is a chapter on rural access so I think we should particularly focus the recommendation on that.

MS. NEWPORT: Just a point of clarification for me is that there was reference in the chapter about Med supp coverage, and we've talked about the M+C stuff. This recommendation is just clearly aligned with the SLIMB, QMB

government programs?

MS. MUTTI: Right, and duals.

MS. NEWPORT: Maybe we want to say that.

MS. MUTTI: In terms of covering Medicare cost sharing? Yes.

DR. WILENSKY: I also was confused about that, because my initial reaction in looking at the wording was that's because there aren't any M+C programs.

MS. MUTTI: Right, we were trying to avoid having to define QMB and SLIMB in the recommendation.

DR. ROSS: Because we couldn't use the acronyms in the recommendation. But we'll be clear about that in the text.

DR. NEWHOUSE: My reaction actually is similar to the discussion that we had this morning about quality differences. That is, the percentage without any form of supplementary insurance is 17 versus 14, which sounds like a small difference relative to the take-up rate in these programs, which I think is more like 60 or 70 percent across the board. So it's in that context I think we should talk

about -- it's really very similar to me to this morning's discussion.

DR. WILENSKY: Okay, then to reword this recommendation, just to make efforts to increase the enrollment in programs that cover premium deductible and cost sharing for eligibles.

DR. WAKEFIELD: Was it in this chapter or someplace else where you reported out data on Medicare beneficiaries' perception of access to or utilization of services -- I can't remember what the issue was -- related to cost? It's in this chapter and it's in this section? Because I think that's an important point to appear alongside of this.

DR. WILENSKY: Maybe you could try to reword this slightly and let us look at the specific language in the morning. But my sense is there's agreement on the sense of the recommendation. We'll look at it and then do a vote in the morning.

MS. MUTTI: I just want to be sure that you're -- there's one more slide and just one more point to make. The

second part of the chapter talks about Medicare rural programs, for lack of a better term, and it summarizes hospital-based and rural health clinic programs, and tries not to overlap with what Jack has done but we'll refer to that. But we really spend most of our time talking about the Medicare incentive payment program and then telemedicine policies.

As we discussed at the last meeting, we weren't going to make any recommendations with respect to the Medicare incentive payment program because we were awaiting an evaluation by RAND, the final report which is due to come out later this year and you were looking forward to having those results before making any recommendations. Also there's an ongoing effort to change the HPSA definition that would be interesting to see how that turns out. So consistent with that, we have no recommendation in this draft.

At the last meeting we also talked about draft recommendations for telemedicine, particularly the store-and-forward technology. Upon further reflection, we would

recommend that that may be too premature to go on that route. We would point out that BIPA made a lot of policy payment changes that have even yet to be implemented. It might be worthwhile to see how those play out, get a little experience with that.

Also, there are two demonstration projects that are going on that are financed through HRSA, I believe. I may have the wrong agency -- but not HCFA, both in Alaska and Hawaii that are using store-and-forward technology. BIPA required that Medicare reimburse store-and-forward technology in those two areas. So in a sense, there is a demonstration on reimbursing this technology and it may be worth waiting for some results from that before we go forward and make our own recommendation. So at this point staff have no recommendation on this topic.

DR. WILENSKY: Joe, did you have a comment?

DR. NEWHOUSE: This is really a comment on tone. We start off, the first fact we come to is the disparity in resources in terms of doctors per person in rural. That really only makes sense if you say that the rural population

tends to use rural providers, although you've been a little better here and say, it's not surprising that they travel to urban areas. But it may also be the case that the nearest provider is actually in a metropolitan area for the -- there's a substantial share of the non-metropolitan population that lives in counties that are adjacent to metropolitan areas, as our data show. For that group, their closest doctor may be in the metropolitan county.

This presumes that if you're in -- the rural population uses only rural providers, and the metropolitan only uses metropolitan. That last assumption is about right, but the first assumption needn't be right.

So maybe just pointing toward the fact that although there's going to be these disparities, in fact when we get to what we think are better measures of access later in the chapter, those measures don't show anything like the kind of disparities you're showing in the resources here. This is what's usually trotted out to indicate problems. In fact we have quite a bit more to say than this, and we ought to signal the reader that this is certainly not the whole

picture.

MS. MUTTI: So I'll just revise the lead-in to that discussion to point that out.

DR. WAKEFIELD: On the Medicare incentive payments I'd just ask you, if you get 20 seconds to maybe give Gary Hart a call out in the state of Washington. I think he's looking at issues around participation rate of physicians in this program and what might be driving their selecting in or not. Because at least anecdotally there's been some concern about the audit rate on bonus payments. Given that these are not very high at the front end, it may well be that there's something else going on and he might be able to tell you something that could be incorporated in here.

I also have a number of comments on the discussion about rural health clinics and ambulance payments, et cetera, but I am sure my colleagues here would do me if I insisted on going through all of those, though you asked for tone. So I'll go ahead and just e-mail them to you or something, if that's all right. But I do have a number of comments on tone.

DR. BRAUN: I just wanted to bring up, in the area where you're talking about the propensity to seek care you talk about there being very little difference even in remote areas, but then the paragraph goes on to theorize on potential barriers to care. I'm wondering, that doesn't seem to hang together. I'm particularly a little bit concerned about the anecdotal situation with the dental. Somehow there's a value thing in there that worries me a bit.

Also under the claims analysis findings, I think that's a good opportunity to talk about neither 71 nor 73 percent are acceptable values of needed care. I think that's a good place where we could bring that out.

There's one other thing I wondered about. On the top of page 15 you have, by design, Medicare does not provide complete comprehensive health care coverage. I'm just wondering what the by design is. I'd rather see that left out, because it seems to me when Medicare came in, the design was to have it sort of equivalent to what would be private insurance. The fact that it's wandered off from the

original design is something else. But I really don't think it was by design, at least not from the beginning.

MS. MUTTI: I have no problem with that. Good point.

On the propensity to seek care, I'll go back and see how it reads. The intention was to lay out the groundwork for saying, there's reasons to think that there would be a lower propensity for rural beneficiaries to seek care, whether it's referral patterns or sociocultural reasons, but the research we did didn't show that disparity. But let me make sure that it reads right.

DR. WILENSKY: Any additional comments? By all means, Mary, give the detail --

DR. WAKEFIELD: To them, right? Though I'd be delighted to go over them with you right now, believe me. I have all my notes right here.

MR. DeBUSK: Let's vote.

[Laughter.]

DR. WILENSKY: Do you have enough guidance for revisions, particularly with Mary's extensive comments to

come your way?

MS. MUTTI: Yes, so the two points that I'm trying to -- actually just to be sure -- is that we want to be more positive and identify strategies to increase participation in these programs, and we want to better define what these programs are by saying that they are programs that cover premiums, deductibles, and coinsurance.

DR. WILENSKY: Government programs. When I looked at this my immediate response, since most people attempt to cover the coinsurance or missing pieces of Medicare through private supplementation, is I didn't immediately think of public programs.

MS. MUTTI: Right. No problem.

DR. WILENSKY: We'll then do the vote on that tomorrow. Any further comments from the commissioners before we go to public comments?

Thank you.

We're going to turn now to public comments. I'd like to ask the commenters to try to keep their comments pointed and brief.